

Hamilton (W. D.)

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Removal of Intra - Ab-
dominal Tumors

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COLUMBUS, O.

Reprinted from the MEDICAL RECORD, May 9, 1891



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STORMY CONVALESCENCE AFTER REMOVAL OF INTRA-ABDOMINAL TUMORS.¹

THE cases forming the subject of this paper are two in number. Hemorrhage and peritonitis, two sources of dread after such procedures, are here dealt with. They emphasize the point that, to have carefully done such an operation is not all that may be required to effect recovery. The surgeon's interest should not decline, even though, after operation, conditions be favorable. A watchful, experienced eye should supervise convalescence for a fortnight at least after removal of such growths. While the call for secondary interference may be urgent, action should be properly timed.

Special treatises have elaborated the technique of abdominal operations. In supra-vaginal amputation of the uterus for fibroid, most surgeons agree that, when practical, extra-peritoneal fixation of the stump is the best method.

In Case I. it was dropped, and that which I feared took place: hemorrhage, and within a few hours; and it nearly killed the patient.

Having passed through this, she had peritonitis, with great distention and obstruction resulting from it. The latter condition supervened at a most unfortunate time. It occurred to a woman who had nearly lost her life from hemorrhage. She was certainly a poor subject for peritonitis. Operative revision was necessary at this stage to relieve her, and was successfully practised. Case II. shows that if there be doubt in the surgeon's mind in re-

¹ Read at a meeting of the Northwestern Ohio Medical Association, December 12, 1890.

gard to the employment of a drainage-tube, he should use one.

CASE I.—Mrs. L. M——, of Bloomingburg, Fayette County, O., was sent by Dr. Foster, of Washington Court House. Twenty-eight years of age, married two years; no children and no miscarriages. Her menstruations were regular, but had of late years been very excessive. In 1885 her abdomen was seen to be enlarged. In June, 1887, after a tedious drive over a rough road, she had great abdominal pain, tenderness, and frequent scalding micturition. This lasted five weeks, confining her to bed. At the time of admission to Mount Carmel Hospital, in November, 1888, pain had about ceased. She was weak and anæmic from persistent menorrhagia. The abdomen was symmetrically enlarged to about the ordinary size of pregnancy at full term. The tumor was semi-fluctuant. Its relations to the womb could not be clearly ascertained. Operation, November 21, 1888, at 2.30 P.M., Dr. Charles S. Hamilton and Dr. Alan N. Dennison assisting. The incision brought into view a solid tumor that had started in the posterior wall of the uterus. The attempt to remove the uterine appendages elicited the fact that it would be impossible to do so without excising the tumor also. A temporary elastic ligature was cast about the stump, and enucleation of the mass was begun. Supra vaginal amputation was finally resorted to as the only practical expedient. The stump being large, the plan was adopted of hollowing it out and stitching it over and over from the bottom with continuous layers of gut. It was closely brought together, until ultimately the union of the peritoneal surfaces left it apparently secured. The provisional ligature was then removed. The appendages had been included with the tumor. The latter—a fibro-myoma—weighed eleven pounds. After cleansing the cavity with warm water, it was noticed that the stump had begun to bleed. The dissection had been carried so deeply that the outside method of fixation could not be done. It was then transfixed with a needle

loaded with heavy silk and tied with a Tait knot. The utmost care was used in its application. This controlled the bleeding effectually for the time. A glass drainage-tube was inserted into the cul-de-sac, and the wound was closed. Pulse 80, tolerably strong and regular. She was put to bed in good condition.

At 9.30 P.M. she was bleeding and her condition was very unpromising. Her face was pinched, pale, anxious, and cold. At 10.30 P.M. pulse, 135 and feeble. The dressings were saturated with blood, which was trickling over the abdominal walls. At midnight, pulse 156, barely perceptible and intermittent. Her breathing was rapid, her extremities were cold. She was restless and apparently moribund. The hemorrhage had ceased. During all this time the foot of the bed was kept considerably elevated. At 12.30 A.M. ten ounces of a warm saline solution were introduced into a vein in the forearm. It refreshed her greatly. She said that she could feel its warming influence. Her color improved and the pulse diminished in frequency and became stronger.

November 22d, 7 A.M.—Was free from pain, had taken some nourishment by the mouth and had retained it. The bleeding never recurred. There was some abdominal distention. A second saline transfusion of eight ounces was given at 8 P.M., and she grew temporarily better.

November 26th.—At 3 P.M. the pulse rapid, flickering, and could not be counted. The distention had greatly increased. Peritonitis with obstruction was present; for, in spite of the frequent and liberal use of salts and enemata in the previous three days, the bowels would not act. Death was again imminent. She was etherized and put on the operating table. The stimulant effect of the anæsthetic was very marked, for her pulse grew stronger under it. The lower five stitches were removed and a hand cautiously introduced. Dark, offensive fluid, and decomposing clots were found in abundance. Adjacent coils of intestines were generally adherent throughout the belly, and were liberated one from another with the

fingers, the pedicle and its immediate environment being left intact. Warm boric solution was used to flush the cavity, a large quantity being required to cleanse it. The drain and stitches were reinserted. It was interesting to note the change in her facial expression, the improvement in pulse, and the marked subsidence of tympanites during the twenty-three minutes in which she was on the table. Her bowels acted freely half an hour later, and several times during the ensuing night. Next morning, at 7.15, pulse 132. The distention had receded completely and she continued to take food at regular intervals. Henceforth the only source of anxiety was the rapidity of the pulse, which was never less than 120, until December 16th, when a large slough came away with the Tait ligature. She was discharged December 25th, and has since remained well.

CASE II.—Miss J. G——, seen in consultation with Dr. Ranney, of New Albany, O., aged eighteen, had been growing large for two years. As a rule, has been regularly unwell since the fifteenth year, when menstruation began. The abdominal increase has been symmetrical and progressive. The courses were absent in February and March, 1889. There was very little abdominal pain at any time, although tenderness sometimes existed. Bowels regular. Facies ovariana well marked. Dulness generally present, excepting at the sides and above the growth, where the crowded intestines yielded resonance. Percussion sounds not modified by change of posture. Fluctuation in every diameter. Vaginal examination: uterus normal and movable. Diagnosis: simple ovarian cyst. Entered the hospital. Three days' careful preparation of patient.

Operation, August 2, 1890, 8.30 A.M., Dr. William K. Rogers assisting. Present, Dr. Ranney, Dr. Stephenson, U. S. Army, and others. Incision, four inches. Simple cyst, weighing thirty-five pounds, few adhesions, pedicle of small size. No difficulty at any stage of the operation. Cavity thoroughly irrigated with warm water. No bleed-

ing of consequence. Wound closed with silkworm gut and no drainage-tube used.

August 4th, 8.30 A.M.—Patient perfectly comfortable, no pain; outlook good. 8.00 P.M.: pulse, 132, patient delirious and very restless, no abdominal symptoms; prescribed twenty grains of sulphate of quinine with as many drops of dilute sulphuric acid, dissolved in four ounces of warm water, and to be given by enema.

August 5th, 7 A.M.—A second dose of fifteen grains was given, as the first injection had not been retained. At 4 P.M., an abatement of symptoms; was taking nutrient enemata every four hours; took some nourishment by the mouth and retained it.

August 6th.—Pulse, 102; temperature, 102° F. Rested well during preceding night. No pain.

August 7th.—Pulse, 78. Bowels acted freely.

August 8th.—Pulse, 78; no tympanites; ate bread and tea this morning.

August 10th.—Pulse, 102; temperature, 101½° F. A tympanitic rounded swelling filled left groin and post-pubic space. Cul-de-sac tender; some pain; enemata not retained.

August 12th.—Extensive peritonitis; general distention; belly and vaginal vault very tender. Pulse, 120. Countenance dusky, giving her a jaundiced look. Bowels acted slightly. Salts failed to produce a proper response.

At 4 P.M. etherized, washed the parietes, removed four lower stitches, and found the wound united. Carried in two fingers. A quart of purulent fluid escaped at once; two or three diverticula, walled with intestines, parietes, or omentum were discovered. Intestines firmly united to abdominal walls at nearly all points about the field of incision. Cul-de-sac full of fluid. The main accumulations were below the wound, as indicated, and above it in the right loin. Washed freely with hot boric water. Inserted a glass drain and closed the wound. Bowels acted seven times during that night.

August 13th, 9 A.M.—Pulse, 72. All distention relieved.

August 26th.—Drain withdrawn.

September 3d.—Slight discharge of pus from lower angle. Discharged September 13th. Has since remained well.

The cases cited are unusual, so far as the necessity of secondary operative interference is concerned. Most of my cases in which operations for the removal of intra-abdominal tumors are required get along in an uneventful way. So far as the facility with which they get well is concerned, the presence of adhesions and of surmountable difficulties in an operative way do not seem to retard convalescence, provided they survive the shock.

It is comforting to know that in a percentage of cases of peritonitis, if ordinary remedial measures fail, we may have recourse to operative revision of the abdominal cavity with some hope of success. If all of the precautions as to cleanliness have been observed, and these are most exacting, a faultless technique should be followed by recovery in a large proportion of cases.

The manner in which peritonitis causes death is evident: The importance and large area of the membrane affected, it being the great open mouth of the absorbent system; the condition of obstruction, due to distention and adhesion of coils of intestine; shock resulting from diaphragmatic pressure; interference with respiratory and circulatory mechanism; the whole depending upon defective drainage or injurious manipulation of the peritoneum.

